General Assembly

Amendment

January Session, 2015

LCO No. **6883**

Offered by:

SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.
SEN. COLEMAN, 2nd Dist.
SEN. DOYLE, 9th Dist.
SEN. SLOSSBERG, 14th Dist.
SEN. GERRATANA, 6th Dist.

To: Subst. Senate Bill No. **993** File No. 613 Cal. No. 353

"AN ACT CONCERNING FACILITY FEES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Affiliated provider" means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school, as defined in section 33-182aa, that is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member;

(2) "Campus" means: (A) The physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(5) "Hospital" has the same meaning as provided in section 19a-490;

(6) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

(7) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility; and

(8) "Provider" means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services.

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or

health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health

system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider;

(2) (A) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) The written notice described in subsections (b) and (c) of this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges.

(e) (1) For nonemergency care, if a patient's appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is

unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

(f) Subsections (b) to (e), inclusive, of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

(g) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting areas, stating that: (1) The hospital-based facility is part of a hospital or health system, and (2) if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based.

(h) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.

(i) Notwithstanding the provisions of this section, on and after October 1, 2015: (1) No hospital or health system shall charge a facility fee (A) for outpatient health care services that use a current procedural terminology evaluation and management code and are provided at an outpatient facility, health care provider's office or other facility located off-site from a hospital campus, or (B) for outpatient services received by a patient who is uninsured of more than the Medicare rate; and (2) each health insurer shall negotiate facility fees as provided in section 2 of this act.

(j) Each hospital and health system shall report not later than July 1, 2016, and annually thereafter to the Commissioner of Public Health concerning facility fees charged during the preceding calendar year. Such report shall include (1) the number of hospital-based facilities

owned or operated by the hospital or health system that provides services for which a facility fee is charged, (2) the number of patient visits at each such hospital-based facility for which a facility fee was charged, (3) the total amount of revenue received by the hospital or health system derived from facility fees at each such hospital-based facility, and (4) the number and amount of facility fees charged at each such hospital-based facility that were paid by Medicare, Medicaid or under a private insurance policy.

Sec. 2. (NEW) (*Effective October 1, 2015*) (a) Each health insurer, health care center, preferred provider network or other entity that contracts with a hospital or health system, as defined in section 19a-508c of the general statutes, as amended by this act, to provide health care services to its insureds or enrollees may negotiate facility fees, as defined in section 19a-508c of the general statutes, as amended by this act, for each such contract that is entered into, renewed or amended on or after October 1, 2015.

(b) Each such health insurer, health care center, preferred provider network or other entity that has agreed to the inclusion and rate of a facility fee (1) shall provide coverage for such fee as part of the related professional services component covered under a health insurance policy or health care benefits plan, and (2) shall not impose any additional coinsurance, copayment, deductible or other out-of-pocket expense for such fee.

Sec. 3. Section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) For purposes of this section:

(1) "Request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "This is not a bill".

(2) "Health care provider" means a person licensed to provide health

care services under chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, chapters 384a to 384c, inclusive, or chapter 400j.

(3) "Enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents.

(4) "Managed care organization" means an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing or amending any individual or group health managed care plan in this state.

(5) "Copayment or deductible" means the portion of a charge for services covered by a managed care plan that, under the plan's terms, it is the obligation of the enrollee to pay.

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee, other than a copayment or deductible, for medical services covered under a managed care plan.

(c) It shall be an unfair trade practice in violation of chapter 735a for any health care provider, hospital licensed under chapter 368v or health system, as defined in section 19a-508c, as amended by this act, to request payment from an enrollee for a facility fee, as defined in section 19a-508c, as amended by this act.

[(c)**]** (d) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to report to a credit reporting agency an enrollee's failure to pay a bill for medical services or a facility fee when a managed care organization has primary responsibility for payment of such services or such facility fee.

Sec. 4. Subdivision (3) of subsection (c) of section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(3) No participating provider, or agent, trustee or assignee thereof, may: (A) Maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center; or (B) request payment from a subscriber or enrollee for such sums. For purposes of this subdivision "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL". The contract between a health care center and a participating provider shall inform the participating provider that pursuant to section 20-7f, it is an unfair trade practice in violation of chapter 735a for (i) any health care provider to request payment from an enrollee, other than a copayment or deductible, for covered medical services, or to report to a credit reporting agency an enrollee's failure to pay a bill for medical services when a health care center has primary responsibility for payment of such services, and (ii) any health care provider, hospital or health system to request payment from an enrollee for a facility fee, as defined in section 19a-508c, as amended by this act."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-508c
Sec. 2	*October 1, 2015*	New section
Sec. 3	*October 1, 2015*	20-7f
Sec. 4	*October 1, 2015*	38a-193(c)(3)